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SOVIET PSYCHIATRY AND THE RUSSIAN CITIZEN

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by

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One cannot understand the delivery of psychiatric services in the USSR without a brief reference to the philosophy and commitment which undergirds the provision of all types of medical care to the Russian citizen.

Soon after the establishment of Soviet power in November, 1917, the People's Commissariat for Public Health was activated. One of its very first decrees gave the highest priority to the organization of medical services available to all of the citizenry.

These principles of the right of every citizen to the highest quality of medical care are spelled out in Statute 120 of the Soviet Constitution, which guarantees that "the citizens of the USSR have the right to material assistance in their old age and during illness and inability to work. This right is assured by the establishment of social insurance of workers and officials on the part of the state, by free medical assistance to workers and the availability to workers of a vast network of balneological stations."

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Over the past 50 years, the USSR has made an extraordinary effort to acquire the medical personnel necessary to achieve the high-sounding goals enunciated in the Soviet Constitution. Before the Revolution, there were 30,000 physicians -- a ratio of little better than one physician for every 10,000 inhabitants; only 46,000 nurses, and only 13 beds for every 10,000 people in the USSR.

In the span of these past five decades, the number of physicians in all specialties has risen to approximately 600,000 -- almost double the figure here in America. The number of nurses has risen to 1,700,000, which is a fantastic increase of 36-fold over 1913. The number of hospital beds (excluding military hospitals) is now estimated at 2,225,000. Approximately 10% of these beds -- in the neighborhood of 225,000 beds -- are for mental patients.

One is at a loss in attempting to portray the intensive planning and unbelievable energy which has gone into this educational effort. Since two-thirds of the Russian people were illiterate at the time of the Revolution, the first priority was given to basic education. Factory schools were started (Rabfaks) where the brightest workers were trained and then sent on to the technical health schools.

Today there are 40,000 students in freshman classes at the medical, pediatric, public health and dental schools, and in recent years they have been graduating 35,000 physicians a year in these categories. If we assume that 5,000 of these 35,000 are either dentists or dental surgeons (stomatologists), a graduating class of 30,000 is four times as large as the comparable number of graduates from American medical schools.

The total number of psychiatrists* in the USSR is estimated at 10,000 -- about half the number of psychiatrists in America. But a comparison of this kind is misleading.

*Note: Also referred to as "psychoneurologists", but still clearly distinguished from neurologists -- those whose entire training and practise is in neurology. Neurologists as sometimes called "neuropathologists".

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First of all, there are 12,000 neurologists in Russia, and many of these treat those mentally ill suffering from organic damage (epilepsy, organic brain damage, etc.). Secondly, psychiatry in the USSR is rarely on a one-to-one basis. The psychiatrist is usually working in a hospital or a dispensary; he is part of a team which is able to deal with numbers of patients.

Over-all statistics of this kind do not convey the astounding richness of personnel resources characteristic of a score or more hospitals and clinics which we visited during our three weeks in the USSR.

Previous American visitors have given us impressive figures on the Kaschenko Hospital in Moscow, which is under the direct surveillance of the Institute of Psychiatry of the Ministry of Health. However, we saw rural hospitals with equally impressive personnel ratios. In a day-long visit to the Vinnitsa Hospital, which is in a rural area in the Ukraine about 150 miles from Kiev we saw a hospital which, at first blush, was startlingly similar to so many of our state hospitals located in rural areas of this country. It housed 1,900 patients, and its buildings showed the ravages of time and the fierce destruction during the Civil War of 1917-1921 and the Great Patriotic War (World War II).

But there the similarities to the custodial American hospital ended. The director of the hospital -- the very vigorous, personable Dr. Roman Marianchik -- was outspoken in his distaste for large dormitories and complacent, custodial care. When he had taken over the hospital twelve years ago, there were as many as 80 to 90 patients on each dormitory. He broke these big dormitories up into small wards averaging eight beds each. He wasn't happy with the eight-bed arrangement -- he told us it was still too depersonalized. His immediate goal is a maximum of four beds to a ward.

He was close to achieving his goal because he could recruit personnel to this relatively remote hospital. The staff consisted of 117 physicians -- a ratio of better than one physician for every 20 patients; some 300 nurses, 150 paramedical personnel, and 772 ward orderlies. In addition, there were 40 residents in psychiatry, a small group of sixth-year students getting bedside training in psychiatry, and a handful of general practitioners who had come to the Vinnitsa Hospital for a postgraduate course in psychiatry.

At the Children's Neuropsychiatric Hospital in Moscow there are 535 beds, plus a fantastically active outpatient service. In the inpatient service there are 27 physicians, 32 logopedes (specialists in speech disorders), 60 teachers, 280 nurses and more than 300 ward orderlies and helpers. On the outpatient service, there are 63 full-time child psychiatrists -- one for every 20 children currently in active treatment. In addition, there are 12 highly prestigious medical doctors on the consultative staff. Most of these have dual appointments at a medical school or research institute. These 12 doctors -- to whom extreme deference was shown -- are the supreme referral and diagnostic resources in very difficult cases for which the staff needs expert help.

The Children's Neuropsychiatric Hospital is also a very important center for the training of child psychiatrists. At the time of our visit, there were approximately 40 residents in child psychiatry. Most of the residents were pediatricians. After completing a rigorous, six-year medical course with a specialization in pediatrics, they practised a minimum of three years as city district or rural physicians. They were now receiving anywhere from one to two years of intensive training in child psychiatry in which the clinical bedside preceptorship and the case history were emphasized, as against a minimal amount of time devoted to academic lectures.

The staffing patterns cited above are not atypical. For example, the neuropsychiatric dispensary is the most important treatment facility in Soviet psychiatry. It is the regional mental health center, usually serving about 400,000 people. In Moscow, for example, there are 19 neuropsychiatric dispensaries. The average dispensary has anywhere from 15 to 25 full-time psychiatrists. The one we visited in Moscow handled 105,000 patient visits in 1966. It logged 1,500 new admissions in that year, and it maintained fantastically complete psychiatric records -- some of them 60 pages in length -- on 12,000 people in its region. The staff consisted of 27 psychiatrists, 35 nurses and scores of additional subprofessional personnel. The staff psychiatrists told us that they averaged 20 home visits a month.

The use of such extraordinary cadres of personnel is never profligate. One gets the impression that there is a constant assessment of the effectiveness of personnel assigned to each different facility.

There is a constant, almost fierce, demand that each physician justify the course of treatment which he is giving to a patient. In an ancillary manner, there is a persistent questioning as to whether the particular facility where the patient is being treated is right for him. In order to arbitrate these intense but friendly disputations among therapists as to the appropriateness or inappropriateness of the kind or locus of treatment, there is a vast proliferation of expert commissions which conduct informal hearings on such matters as where a child with a severe character disorder should be sent, or just what job capacity and potential an emotionally disabled worker has and to what work he should be assigned, and so on.

The most difficult concept the American visitor must assimilate -- and this usually hits him with tremendous impact in the last few days of the tour -- is the prodigious

variety of institutional settings in which the Soviet child or adult suffering from mental illness can be placed. There is an exceptionally precise delineation of the varying therapeutic functions of these institutions and schools; it takes a fair amount of time to realize that the disposition of each patient is very carefully related to the functions of these facilities, whether they be in the Ministry of Health, the Ministry of Education, the local Ministries of Social Security, or whatever.

Leaving aside the paramount virtue of a psychiatric system which brings a high quality of care to all those in trouble without any invidious economic distinctions, it is my considered opinion that the tailoring of psychiatric care in all kinds of settings -- in the school, in the factory, in the dispensary, in the emergency services, in the home -- to the individual needs of each patient is the crowning achievement of Soviet psychiatry. Let me illustrate this in the care of three segments of the Russian population:

THE CHILD

Child care begins on an intensive and meticulous basis with the pregnant mother. From the fifth month of pregnancy, there is the beginning of an accumulation of a vast amount of physiological data on the child yet to be born. After the mother delivers the child, the children's polyclinic is immediately notified by the hospital. These polyclinics are the medical hub of all services for children -- there is one in each district serving approximately 15,000 children. The children's polyclinic also provides most of the medical and psychiatric services for children in the kindergarten and in the schools. When the child is ready for kindergarten at the age of three years, it is the polyclinic which gives him a physical and psychological examination. The same process is repeated when he enters elementary school at the age of seven years.

Emotional problems in children are usually detected by the pediatrician. A high level of individual care is possible because there are 70,000 pediatricians in the USSR,

as compared to about 15,000 in this country. The pediatrician knows the family situation intimately. From the time of the child's birth, she has spent a great deal of time with the family in the home situation, and she can make a judgment based on a whole set of factors which would not be known to her in a perfunctory outpatient visit. If psychiatric treatment is needed, she refers the child to the child psychiatrist on the staff of the polyclinic. It is obvious to any visitor that it is a tremendous advantage to combine pediatric and psychiatric services under one roof -- to have what amounts to a continuing consultation between the two disciplines which have so much to do with the successful maturation of the child.

Where treatment is indicated, there is an amazingly varied constellation of resources tailored to the severity of the child's problem:

1. For children under the age of three, there is a vast network of nurseries. It is estimated that more than 50% of Russian children get their early upbringing in these nurseries. Working parents may leave them in these nurseries during the entire working week, just bringing them home for weekends. In addition to intensive pediatric care, the nurseries in recent years have concentrated on developing educational staffs to motivate the child and introduce him to the learning process. If the psychiatric consultant to any of the regular nurseries detects an emotional problem in a child, he can transfer him to one of the specialized nurseries which handle psychiatric disorders in children.

2. From the ages of four to seven, the child goes to a kindergarten which may be located in the district where he lives, or in the factory in which his father and/or mother works. Here again psychiatric consultation is available, and there are several specialized kindergarten schools for disturbed children.

3. For children who cannot perform adequately in the educational system, there are a host of options open to the psychiatric-pediatric team which is treating him. If the

child suffers from a neurotic or learning difficulty, there are special sanatoria where children reside full-time and receive both psychiatric and educational help over a period of from three to six months designed to return them as soon as possible to the regular schools. For more disturbed children, there are residential Forest schools which have year-round programs emphasizing both work and study activities directed toward bringing about motivational changes in the child. For severely ill, but treatable emotionally disturbed children, there are specialized children's hospitals which have a staff-to-patient ratio which would be impossible to achieve in this country at the present time.

Although there are a wide variety of treatment situations into which particular types of childhood mental illness can be fitted, the most impressive strength of the Russian system is the delegation of responsibility for each child. For example, the neuropsychiatric dispensary child psychiatrist, who actually works at the children's polyclinic, is expected to follow his emotionally disturbed charge from the initial date of contact until the child reaches 15 years of age.

When the child becomes 15 years of age, continuity is not lost. He and his voluminous records are transferred to a special psychoneurologic clinic for adolescents which is usually located adjacent to the psychoneurologic dispensary of the region. Each of these clinics handles approximately 15,000 adolescents. When the age of 18 is reached, adolescents and their dossiers are transferred to the regular NP dispensary in the region.

All facilities and agencies which handle children and adolescents are reinforced by intensive, expert medical-consultation teams which work out of the NP dispensary. These teams provide help for polyclinic pediatricians, for regular and/or auxiliary school physicians, for speech therapists and regular teachers in the pre-kindergarten, kindergarten and school settings, and for overseers and foremen in factories where adolescents work. When called upon, they participate in visits to the homes of the patients, and they frequently interview the parents in either the home setting or at the dispensary.

There is no doubt that the Russian children's polyclinic -- strongly backed up by the children's department of the outpatient neuropsychiatric dispensary -- is far superior to the American child guidance clinic. In America, continuity of service is almost totally absent, the child may be buffeted about between a pediatrician, a child psychiatrist, a clinic welfare agency or what-have-you, with very little in the way of mutual consultation and medical follow up. The Russian system is impressive because it is based upon joint pediatric and psychiatric responsibility for the child. He is not lost in a welter of agencies -- the district polyclinic is home base for him and it has all his records, medical and psychiatric, from infancy. Furthermore, the polyclinic takes care of the total child -- the doctors see him in the home, or in the kindergarten, or at grade school. They don't have to break down any jurisdictional walls to do this. The dispensary child psychiatrist, for example, must spend an assigned number of hours each week in home visiting or in consultations.

The exceptional amount of professional time which is devoted to a precise evaluation and assessment of just what facility is most appropriate for each individual in trouble is a constant wonder to the American visitor. Initial assignments of children, or re-assignments during a later course of treatment, are rarely left solely to the psychiatrist who has major responsibility for the child; the most typical pattern is an expert commission which examines the child and his records and then recommends a disposition.

For example, children under the age of four with sequelae resulting from an organic attack upon the central nervous system are studied by a special commission composed of a pediatrician, a psychoneurologist, and a representative of the local governing health unit before being assigned to special pre-kindergarten schools or homes for these children. For children who have mild forms of mental deficiency -- who have reached the age of

own experiences and point out the possibility of maintaining sobriety. The staff frequently reads to the groups letters from former patients and their relatives; these are then discussed within the group.

Activity in the industrial workshop is a very important part of the restorative regime for alcoholics. Hard work for which they are paid teaches these alcoholics "new moral values". Work which involves large groups of muscles stimulates the central nervous system. Work assignments should be tailored to the individual needs of the patient, but according to Loukomski "they should not only impart to the patient a feeling of 'muscular joy' as I. Pavlov used to say, but also the moral satisfaction brought by accomplishment and the awareness that he is a useful member of society."

In the specific treatment situation, the Russians have been using aversive therapies to produce a conditioned negative reflex to alcoholism since the early 1930's. They are quite sophisticated in the pharmacological therapy of alcoholism. They regard antabuse as too dangerous in its side effects for most patients -- they prefer nicotinic acid, which they contend both sensitizes the organism to alcohol and restores the vitamin metabolism of alcoholics.

In the actual treatment of the alcoholic state, they employ a wide variety of neuroleptics, and again the precision and sophistication of their use is impressive. For example, stelazine is utilized in handling both acute and chronic alcoholic hallucinosis. For the treatment of delirium tremens (known as "white fever" in Russia), a wide variety of tranquilizers is applied. For compulsive forms of alcoholism diazepam is used, and in other forms of alcoholism, librium is administered. Despite extensive dispensing of pharmacological agents, the Russian narcologists to whom we spoke generally rejected undue

THE WORKER

In the USSR, the psychiatric treatment of the worker and his eventual readaptation to some level of working ability are inextricably bound together. This is their form of social psychiatry; as one of the doctors we visited at a factory phrased it, it represents "the unity of clinical and social medicine".

For the worker who is hospitalized, the plan for his eventual return to a productive role in society is begun almost on the day of his admission. Most frequently his psychiatrist, the doctor assigned to the workshop, and the industrial therapist do a joint assessment and assign him to an activity which he can handle in the workshop. For example, workers with previous experience in factories are assigned to the heavy industrial component of the workshop.

Regulated pay for work performed is viewed as a powerful therapeutic and motivational force in the treatment of the disabled worker. The dignity of work is enshrined in the Soviet culture; Russian psychiatrists feel very strongly that the continuation of work habits while under treatment keeps the patient from regressing into dependency and losing his self-esteem.

Those who are day patients at the NP dispensary usually put in a regular six-hour work day, and they are paid the full price for their output on a piece work basis. The only deductions are for food and drugs. Inpatients in hospital workshops retain thirty percent of what they earn, with the remaining 70 percent covering their food, drugs and luxuries such as new recreational equipment, trips by bus into the countryside, and so on. Profits from the shops, over and above what is paid to the patients, are set aside for new buildings or repairs for the workshops and dispensaries.

Even the most severely emotionally disabled workers -- the "nadomniki" who work at home because they cannot fit into the regimen of the workshop -- receive the ample fruits of their toil. The NP dispensaries supply them with the raw material, and they can earn the full market value of what they produce on a piece-work basis.

When we were asked what system we used to compensate mental patients in American mental hospitals, we were embarrassingly and eloquently silent. We were not eager to describe the artsy-craftsy nonsense which we euphemistically call "occupational therapy", nor were we prepared to disillusion our Russian hosts with a graphic account of how thousands of our mental patients work at menial tasks without either pay or dignity -- custodial peons at the very bottom of the capitalistic pecking order.

If the patient has a good recovery in the hospital, he is returned to his previous place of occupation. The factory or agency must take him back, and they must provide him with work suited to his physical and psychological condition as described in the medical report signed by his psychiatrist and the hospital. His labor union keeps a careful watch to see that the factory follows the medical recommendations; it frequently employs a physician who negotiates with the factory authorities and with the hospital staff on behalf of the patient.

The USSR has devoted an extraordinary amount of attention to the determination of work capacity. The Soviet literature is replete with reports of clinical studies of work capacity among the mentally ill. Several schools of psychiatric thought have concentrated on the various stages of disability, the residual deficits as a result of hospitalization, compensatory mechanisms to overcome the deficit, and so on. The Russians are very proud of their truly pioneer work in setting up workshops in hospitals and dispensaries more than 40 years ago; they are equally proud of the sophisticated institutions they have developed for the transition of the worker from incapacity to productivity. They regard this as a strongly professional endeavor; as D. E. Melekhov pointed out recently, they have "no clubs for independent amateurs who wish to help these patients".

Since World War II, the USSR has created a new agency for the evaluation of work capacity of mental patients. These agencies are called psychiatric VTEK's, commissions

composed of two psychiatrists, one industrial therapist and one neurologist. There are VTEK's in all the Republics of the USSR at the present time, and their determinations are legally binding on all work installations in the country. They assess the degree of loss of work capacity, and they make clear-cut vocational recommendations as to just how much work the patient can handle. If the patient is severely or totally disabled, they make recommendations to send him to a Home for the Invalids under the Ministry of Social Security, or to his family or some form of guardianship. They also establish the levels of disability pensions to which all Soviet workers are entitled.

Since they have a strong belief in the restorative capacities of man, they do not certify a patient as totally disabled until he has failed to respond to all therapeutic measures and has subsequently been unable to return to work in a carefully modified, tailored situation;

The Russians feel that their tremendous efforts in the field of work rehabilitation have paid off handsomely. Melekhov estimates that among disabled persons with mental pathology, only 10 to 15% are in mental institutions, whereas 85 to 90% are functioning to some degree in the community. All of the latter are under constant surveillance by the regional NP dispensary; many of them are receiving pensions due to loss of work capacity, but they are not immobilized in a massive institution.

Our tour of one of the largest auto factories in Russia, the Likhatchov Motor Plant in Moscow, confirmed our impressions of the excellence of industrial medical care in the Soviet Union. The plant employs 70,000 workers and it manufactures trucks, lorries, and a luxurious passenger car -- the Zil.

The medical unit is divided into a polyclinic with 16 very active medical departments, and its own inpatient department with several hundred beds. Under the aegis of the medical

unit, there is also a tuberculosis sanatorium and 22 smaller medical units spread over the outlying districts covered by this factory and its subsidiaries.

The factory medical service is in many ways the most unusual and dynamic medical facility in Russia. It is a great convenience to the workers to be able to receive all their medical care at the same place where they work. If they prefer, they can also bring their families in for treatment. The Likhatchov factory has a medical staff consisting of 600 medical workers, including 150 physicians and 270 paramedical personnel. On a typical day, it handles 2,600 patient visits in its various specialized units. It also has a special department for adolescents working at the factory.

The medical unit is backed up by a large consultant staff from some of the finest research institutes in the USSR -- the Institute of Therapy of the Academy of Medical Science, the Institute of Neurology, the Institute of Industrial Hygiene and Occupational Diseases, the Institute of Expert Testimony on Working Capacity, and so on. In addition, there are special occupational pathologists who constantly evaluate the medical examinations done by the physicians in the plant.

All workers in the plant receive an annual physical examination. A special occupational pathology department monitors very closely the 12,000 workers who have contact with dangerous chemicals, or are subject to excessive noises, air pollutants, and so on -- these workers receive a complete and thorough physical screening twice a year.

There is a special program for the care of workers who suffer from emotional problems. If an annual examination detects some emotional difficulty, the worker is immediately referred to the psychiatry department, which consists of two full-time psychiatrists. Alcoholism is a big problem among workers; there is a narcologist who works solely in the

treatment and rehabilitation of alcoholics. In addition to aversive therapies, the narco-logist devotes considerable time to checking up on the work situation and job capacity of the alcoholic. If he finds the job is too dangerous or too much of a strain, he will recommend that the worker be transferred to another unit in the factory.

There are also nine neurologists on the staff of the factory medical unit and, as we have stated before, these neurologists handle many cases of organic mental illness.

The psychiatric unit is a fairly active one, with about 30 visits a day. In our conversations with many members of the medical staff and two or three of the foremen, it was interesting to note that there was very little evidence of the traditional stigma concerning mental illness. One of the foremen said that when one of the workers has an emotional problem, his fellow workers are quite understanding and try to help. If they do not succeed, they suggest that the worker go to the medical unit.

All factories have large budgets for medical care. While the local health departments pay the salaries for medical personnel in the factories, all other services are provided from the "profits" made by the factory. While proud of its present facilities, the medical director of the Likhatchov Plant pointed out that the trade union committee of the factory had recommended building for him a new hospital of 1,100 beds which would cost eight million rubles. This is a heavy expenditure even by American standards, but the director proudly assured us that the factory Board of Directors and the trade union placed the highest premium on good medical care.

THE ALCOHOLIC

Preventive and therapeutic approaches to alcoholism in the USSR are both dynamic and singularly flexible. They challenge to their very roots many of the bromides about the supposedly doctrinaire, quasi-theological nature of Soviet psychiatry.

We were prepared to expect -- on the basis of earlier reports in the literature and a natural American suspicion of foreign behavior -- a rather vehement denial of the existence of severe mental illness in the Soviet Union. We were almost hoping, after several weeks of our tour, for the long anticipated contention that a socialist society provided the ingredients for an end to the tensions and conflicts which cursed the family of man in other parts of the world. Our hopes were never realized; the frank discussions about alcoholism serve as a superb illustration of why they were not.

Without exception, all of the psychiatrists, educators and public health officers to whom we talked agreed that alcoholism was a most serious problem in the USSR. They referred to the Russian "alcoholic tradition", noting rather sadly that many special holidays in the year were always celebrated by excessive drinking among both the old and the young. To combat these harmful tendencies, they have mounted a continuing and intensive educational campaign. Posters pointing up the evils of alcohol were seen in all the factories, schools and apartment houses we visited. A wide variety of anti-alcoholic films is shown at labor union, club and cultural association meetings, and narcologists lecture to these groups quite frequently.

Alcoholics compose a large part of the patient load of the psychoneurological dispensaries -- in several of those we visited, as high as 25% of the total number of patients in the active treatment register of the dispensaries were alcoholics. The psychiatrists at the dispensaries, assisted by Social Service nurses, make a very determined effort to check out all of the environmental influences which contribute to the drinking of the patient; if he is a worker in a factory, they talk to the labor union and pinpoint those in the union who encourage him to drink. They also search out relatives and friends with whom he has been drinking, and they charge them with the responsibility of helping to change the patient's attitudes. Their therapeutic approach to alcoholism is dynamic, aggressive

and highly directive. They place the heaviest emphasis upon individual and group conditioning behavior. They do not -- and this surprised us -- place much stress upon the physiological bases of alcoholism. This position is most clearly expressed by I. I. Loukonski:

"Regardless of any position as to the 'biological' basis of alcoholism, none of us doubt that the patient's own behavior plays an overwhelming part in the development of alcoholism and in the aggravation of the clinical picture of the disease."

Initial conditioning is done in a group therapeutic setting in either the hospital or the dispensary. Patients are assigned to arduous daily duties; failures to perform these duties are punishable by a vote of one's fellow patients in consultation with staff physicians. Although there is no organization in the USSR comparable to our Alcoholics Anonymous, the treatment group is frequently visited by former alcoholics who relate their own experiences and point out the possibility of maintaining sobriety. The staff frequently reads to the groups letters from former patients and their relatives; these are then discussed within the group.

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"Thus far, little has been accomplished in the treatment of alcoholics through the use of modern psychotropic drugs. We must probe deeper... psychotherapy must play in it (alcoholism) an important part."

Although we hear much in America lately to the effect that the alcoholic is a sick person and should not be arbitrarily jailed, actual practise falls severely short of this ideal. In Russia, where the rhetoric on this matter is quite limited, performance is infinitely superior.

If an alcoholic is picked up on the streets by the police in Russia, he is taken to the police station, but he is not thrown into a jail cell. There is a separate unit of the jail -- usually consisting of four to six beds -- which is called a sobering-up station; it is manned by a doctor and either a feldsher or nurse. The important point here is that the first contact of the alcoholic is with a doctor. If the alcoholic has a heart

condition, for example, only a doctor can determine this and act accordingly. If the alcoholic has the "white fever", the doctor can determine this quickly and either hospitalize him or use a drug to help him. If he doesn't have to go to the hospital, the alcoholic is given a bed in the unit to sleep it off. The next morning, he is driven to his home or place of work by a police officer. The factory and the family are informed of his detention as an alcoholic; either the patient, or the family, must pay the costs of the previous night's lodging and medical care.

OVERALL IMPRESSIONS AND CONCLUSIONS

1. Continuity and Availability of Care

In many ways, this is the most impressive feature of Soviet psychiatric care. The Russian citizen knows where the district polyclinic is; the mother knows where the children's polyclinic is; the worker has ready access to the medical unit in the factory, and all Russians know the telephone number for emergency medical care.

There is an almost fierce emphasis upon physician responsibility for constant contact with patients. If a patient does not come in for a regularly scheduled visit, he is contacted by letter and then, if necessary, by a visit to his home to bring him to the polyclinic or to the dispensary.

Medical records are notably complete. Card indexes are arranged geographically, so that a psychiatrist in a dispensary can quickly locate the medical record of a patient living on a certain street in a particular microdistrict. Within the geographic umbrella, the cards are usually arranged by severity of illness -- those in the active file who need constant attention, those in the passive file who come in for routine checkups, and the remainder who are not in treatment status, but whose records are kept for future disposition. A special tab fixed to a card notes the need for house calls, or regular active summoning of the patient to the dispensary.

2. Quality of Care

After visiting psychiatric installations of all kinds in urban, rural, factory, school and emergency settings, there is no doubt as to the competence and dedication of the Russian psychiatrist, nurse, and paramedical worker. There is a great warmth between therapist and patient. This is combined with a contagious air of optimism concerning the recovery of the patient. No patient is to be written off -- even among the chronic patients in the Homes for the Invalids or in the institutions for the mentally defective, the staff works to make the patient as happy as possible, and as active as possible, within the limitations of the patient's infirmity.

This intensity of treatment is achievable because the USSR has devoted a large percentage of its limited resources to the health personnel education system. Furthermore, it devotes a considerable additional portion of its budget to protecting the material and psychological security of all its citizens through disability payments, old age pensions and other forms of social security. L. G. Véber estimates that, in 1965, approximately 20% of the USSR budget was devoted to expenditures for public health, physical culture, social security and state social insurance.

3. The Role of the Citizen in Mental Health Care

There is no tradition of active voluntary citizen participation in determining the level of care or influencing other priorities within the Soviet mental health system. The literature which we received made much of the functions of the Red Cross and (in Moslem areas) the Red Crescent societies in aiding the health authorities; we were told that these organizations boasted a combined membership in excess of 60 million people. In actual fact, the role of these organizations is very limited; the Russians don't have much regard for the amateur volunteer.

Analogously, there is no local community volunteer effort. In Russia, there are no communities in the sociological sense; for a Russian worker, his community is the factory during the day, and the apartment house where he lives at night and on week-ends.

However, it would be quite mistaken to conclude that there is no citizen pressure upon the mental health system. Time after time during our tour, I asked officials if they ever received any criticisms or complaints from the families of patients. Their initial response was incredulous -- how naive could an American visitor be? They then related incident after incident in which the relatives complained about the quality of care, the food, and whatever. One of the hospital superintendents told us that the citizens were his greatest ally in getting additional money for the hospital:

"When I tell them that I do not have enough money to do all the things they want me to do, they go to the Ministry of Health of the USSR to complain. They are not intimidated. They will wait for hours in the halls until someone from the Ministry sees them. They have been told that Russian people are entitled to the finest medical care free of charge, and they chastise the Ministry for disobeying the Constitution."

The citizen muscle is most apparent in the labor unions. Many of these labor unions -- as at the large motor car factory we visited in Moscow -- have a tremendous say in spending the "profits" of the factory. They meet constantly with management, sometimes as much as once a week, to plan health measures for the worker. In order to keep a close check on management, they sometimes employ physicians on their own whose job it is to guarantee decent medical care for the workers. The trade unions insist upon adequate safety and health-protecting devices in the plant; they also are deeply involved in the planning of new hospital beds and other facilities. One of their major responsibilities is the administration of social security funds -- compensation for workers who are temporarily or permanently disabled.

4. Planning of Mental Health Services

In a rather completely controlled society, planning assumes awesome proportions. All new services must be justified in great bureaucratic detail. There are constant meetings to plan these activities at the Ministry of Health level of the USSR, and at the level of the local Health Ministries within the fifteen Republics which comprise the Soviet Union.

We expected such planning to be monolithic and unilateral -- the Ministry of Health of the USSR would announce its plans and there would be immediate acquiescence and compliance at all local levels. In many respects, the contrary is true. In all of the Republics, there is a yeasty regional pride which resists edicts from Moscow. The officials of the Ministry of Health of the USSR recognize this; they reminded us, somewhat ruefully, that no innovation could be carried through unless it was understood and accepted by the local people. As an example, they cited their position on the expansion of psychiatric units in general hospitals; they wanted more, but the local Ministries of Health were not persuaded of the great virtues of these psychiatric units. As a result, there are only two psychiatric units in general hospitals in all of Moscow, and very few throughout the rest of the country.

What are the lessons for the delivery of better mental health services in America from the foregoing description of the Russian system? We cannot, and would not, want to duplicate some of the controlled aspects of Soviet psychiatry. But there are certain features of the Soviet system whose obvious desirability is worthy of emulation:

1. Of course, the major attraction of the system is that it has removed the economic barrier to good psychiatric care for all of its people. In many ways, this is the most shocking failure here in America. Under a predominantly fee-for-service system, only three percent of our people can afford private psychiatric care. The health insurance industry here moves with glacial slowness to cover the economic costs of mental illness.

2. We have been attempting since 1963 to create a network of community mental health centers designed to provide mental health services to our people in, or close to, the communities in which they live. We have had some successes, but we are constantly inhibited by our inability to pull fragmented services together.

We have much to learn from the Russian concentration upon the individual patient. It is not the agency which dictates the level or scope of service -- it is the patient. Continuity of care, maximal physician responsibility and the breaking down of conflicting jurisdictions is mandated in Russia by the continuing assessment of all facilities as to how well they treat and follow each **patient** throughout the span of his life.

3. Finally, we have much to learn from the emphasis in Russia upon the training of adequate numbers of health personnel. Despite the enormous competitive pressures from other segments of the economy for skilled workers, the Ministry of Health of the USSR conducts a successful battle for increased funds for the training of more health personnel. The brilliant Deputy Minister of Health, Dr. Venediktov, talks impatiently of being limited by having only 600,000 doctors for a population of 230,000,000 people (this compares with less than 300,000 doctors for more than 200,000,000 people in this country). Dr. Venediktov wants 700,000 doctors by 1970, and he is expanding medical schools and building new ones to achieve his goal.

Compared to both Russian achievements and boldly announced aspirations, our American goals these past few years, during the so-called community psychiatric revolution, seem rather limited in that they do not fundamentally challenge out-moded ways of delivering services which are conditioned upon ability to pay.

I submit that the time has now come for a more profound examination of our mental health delivery system, with an eye toward bringing the boon of psychiatric care to millions of Americans whom it does not reach today.